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**UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS**

NO. 15-4524

DONALD R. BULLOCK, APPELLANT,

V.

ROBERT A. McDONALD,  
SECRETARY OF VETERANS AFFAIRS, APPELLEE.

Before PIETSCH, *Judge*.

**MEMORANDUM DECISION**

*Note: Pursuant to U.S. Vet. App. R. 30(a),  
this action may not be cited as precedent.*

PIETSCH, *Judge*: The pro se appellant, Donald R. Bullock, appeals a November 16, 2015, decision of the Board of Veterans' Appeals (Board) that, among other things, denied entitlement to an initial disability rating greater than 30% for post-traumatic stress disorder (PTSD) with alcohol abuse in remission. Record (R.) at 2-15. This appeal is timely, and the Court has jurisdiction pursuant to 38 U.S.C. § 7252(a). The appellant submitted an informal brief, and the Secretary submitted a brief. A single judge may conduct this review. *See Frankel v. Derwinski*, 1 Vet.App. 23, 25-26 (1990). For the reasons set forth below, the Court will vacate the Board's decision and remand it for further proceedings consistent with this decision.

**I. FACTS**

Mr. Bullock served on active duty in the U.S. Army from July 1988 to July 1992. R. at 258. In February 2010, he filed a claim for service connection for PTSD, R. at 516-21, and he submitted a private psychiatric examination report from Dr. Jabbour, R. at 95. The examination report shows that Mr. Bullock reported symptoms of flashbacks, nightmares, major insomnia, inability to focus or concentrate, anxiety, irritability, anger, and depression. R. at 96. He reported suicidal ideation that Dr. Jabbour indicated "had decreased lately." *Id.* After a mental status examination, Dr.

Jabbour found Mr. Bullock's mood was anxious and depressed with some psychomotor retardation. *Id.* Dr. Jabbour also found that Mr. Bullock's thought processes were goal-directed and logical and his speech was within normal limits. *Id.* There was no evidence of psychosis or delusions, he was alert and oriented, and he had good insight and judgment. *Id.* Dr. Jabbour diagnosed chronic PTSD and assigned a Global Assessment of Functioning (GAF) score of 39. R. at 97.

In May 2010, a VA regional office (RO) denied service connection for PTSD. R. at 324-29. Later that month, Mr. Bullock filed a Notice of Disagreement (NOD). R. at 322-23.

In July 2011, Mr. Bullock underwent a VA psychiatric examination. R. at 605-10. He indicated that he had a good relationship with his parents and a fair relationship with his wife, children, and stepchildren. R. at 606. He reported that he had worked for a tire company since his separation from service. *Id.* The examiner noted that Mr. Bullock abused alcohol until 1999 but now was recovering. R. at 607. The examiner found "[t]here were no consequences of the abuse." *Id.* Mr. Bullock reported symptoms of suspiciousness, hypervigilance, chronic sleep impairment, and depression. R. at 605, 609. Upon examination, the examiner found that Mr. Bullock was oriented to person, place, time, and purpose; that his appearance and hygiene were appropriate; that his behavior was appropriate; that he had a depressed mood and affect; that he possessed normal communication, concentration, thought processes, judgment, and memory; and that he had no panic attacks, delusions, hallucinations, obsessive-compulsive behavior, suicidal ideation, or homicidal ideation. R. at 607. The examiner diagnosed chronic PTSD with alcohol abuse in remission. *Id.* The examiner assigned a GAF score of 60, R. at 608, and he concluded that Mr. Bullock's "psychiatric symptoms cause occupational and social impairment with occasional decrease in work efficiency and intermittent inability to perform occupational tasks as evidenced by depressed mood, chronic sleep impairment and suspiciousness," R. at 609.

In September 2011, the RO granted service connection for PTSD and assigned an initial rating of 30%, effective February 10, 2010. R. at 293-308. Mr. Bullock filed an NOD arguing that the RO mischaracterized the severity of his symptomatology as "mild" because the July 2011 VA examiner assigned a GAF score of 60. R. at 289. Mr. Bullock asserted that the GAF score of 60 instead indicated "moderate" PTSD symptoms. *Id.* Mr. Bullock also argued that the RO improperly disregarded the opinion of Dr. Jabbour, his treating physician, who found Mr. Bullock had "major

impairment" due to his PTSD symptoms. R. at 291. In April 2013, the RO issued a Statement of the Case (SOC), R. at 264-82, and Mr. Bullock perfected his appeal to the Board, R. at 263.

In an August 15, 2013, VA treatment record, Mr. Bullock indicated that he had previously lost his temper and disagreed with a superior at work, which resulted in a suspension from work. R. at 147.

In June 2014, Mr. Bullock underwent a second VA psychiatric examination. R. at 539, 548-56. Mr. Bullock reported getting along well with his wife, children, and mother. R. at 551-52. He stated that he had worked full time for the same tire company for the last 14 years. R. at 552. He indicated that he was written up for an infraction three years prior. *Id.* Mr. Bullock's symptoms included depressed mood, anxiety, suspiciousness, and chronic sleep impairment. R. at 554. The examiner noted that Mr. Bullock was alert, cooperative, able to work full time, and able to manage his finances. R. at 555. The examiner concluded that Mr. Bullock's PTSD symptoms resulted in "[o]ccupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks, although generally function satisfactorily, with normal routine behavior, self-care and conversation." R. at 550.

In July 2014, the RO issued a Supplemental SOC (SSOC), R. at 221-224, and in March 2015, the Board remanded Mr. Bullock's claim to obtain additional private and VA treatment records, R. at 209-12. Thereafter, Mr. Bullock's private treatment records from Dr. Jabbour were obtained and associated with the claims file. R. at 74-97. The treatment records show that from 2010 to 2015, Mr. Bullock consistently reported symptoms of anxiety, insomnia, flashbacks, nightmares, anger, irritation, problems concentrating, and disinterest in socializing. *See, e.g.,* R. at 74 (reporting anxiety, flashbacks, nightmares, insomnia, discomfort in crowds, and general mistrust in people); R. at 78 (reporting irritability about work, problems with socialization, anxiety, flashbacks, and nightmares); R. at 80 (reporting not having a social life, mistrust in people, staying away from crowds, problems communicating at home, and anxiety); R. at 82 (reporting that he was "stressed out tremendously" by work, irritability, and anger). At times, he denied suicidal ideation, homicidal ideation, and hallucinations. *See* R. at 78, 80, 84. Mr. Bullock reported panic attacks at September 2011 and June 2012 treatment sessions. R. at 86, 89. Between February 2010 and April 2015, Dr. Jabbour assigned GAF scores between 39 and 45. R. at 78, 80, 97.

Mr. Bullock's VA post-service treatment records were also obtained and associated with the claims file. R. at 57-66, 112-208. The records show that from 2011 to 2015, Mr. Bullock consistently reported insomnia, nightmares, panic attacks two or three times a month, and seeing moving shadows several times a week. *See, e.g.*, R. at 118 (noting continued difficulty sleeping); R. at 121 (noting continued symptoms of occasional hallucinations, panic attacks about twice monthly, and nightmares); R. at 125 (noting reports of seeing shadows "once in a while," having nightmares once or twice a week, and having panic attacks two to three times a month); R. at 129 (noting reports of nightmares once or twice a week, panic attacks two or three times a month, and anxiety); R. at 147 ("Still sees shadows of things running across the room or outside 3-4 times a week."); R. at 175, 177 (noting reports of discomfort around people, panic attacks two to three times per week, and "seeing a 'blurr' [sic] out of the corners of his eyes").

At a September 2, 2015, treatment visit, Mr. Bullock reported feeling mad, anxious, and depressed due to marital problems that resulted in his separation from his wife, and the examiner found that Mr. Bullock was alert, had normal speech, denied hallucinations, and denied suicidal and homicidal ideation. R. at 59-60.

In September 2015, the RO issued an SSOC continuing to deny an increased rating in excess of 30% for PTSD. R. at 42-53. In November 2015, the Board issued the decision here on appeal.

## II. ANALYSIS

PTSD is evaluated under the general rating criteria for mental disorders found at 38 C.F.R. § 4.130, Diagnostic Code (DC) 9411. In evaluating mental disorders such as PTSD, the Board must consider all the evidence of record, determine the nature of the appellant's overall disability picture, and then look to the list of symptoms outlined in the diagnostic criteria as examples that can provide guidance in determining the severity of the appellant's condition. *Mauerhan v. Principi*, 16 Vet.App. 436, 442 (2002). Under DC 9411, a 30% disability rating is warranted when there is

[o]ccupational and social impairment, with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal), due to such symptoms as: depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment, mild memory loss (such as forgetting names, directions, recent events).

38 C.F.R. § 4.130, DC 9411 (2016). A 50% disability rating is warranted when a claimant's mental disorder results in

[o]ccupational and social impairment with reduced reliability and productivity due to such symptoms as: flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short- and long-term memory (e.g., retention of only highly learned material, forgetting to complete tasks); impaired judgment; impaired abstract thinking; disturbances of motivation and mood; difficulty in establishing and maintaining effective work and social relationships.

*Id.* A 70% disability rating is warranted when a claimant's mental disorder results in

[o]ccupational and social impairment, with deficiencies in most areas, such as work, school, family relations, judgment, thinking, or mood, due to such symptoms as: suicidal ideation; obsessional rituals which interfere with routine activities; speech intermittently illogical, obscure, or irrelevant; near-continuous panic or depression affecting the ability to function independently, appropriately and effectively; impaired impulse control (such as unprovoked irritability with periods of violence); spatial disorientation; neglect of personal appearance and hygiene; difficulty in adapting to stressful circumstances (including work or a worklike setting); inability to establish and maintain effective relationships[.]

*Id.* Pursuant to a VA regulation, "where there is a question as to which of two evaluations shall be applied, the higher evaluation will be assigned if the disability picture more nearly approximates the criteria for that rating. Otherwise, the lower rating will be assigned." 38 C.F.R. § 4.7 (2016).

In *Vazquez-Claudio v. Shinseki*, the Federal Circuit held that assignment of disability ratings under DC 9411 requires a two-part analysis of (1) an "initial assessment of the symptoms displayed [. . .] and if they are the kind enumerated in the regulation," and (2) "an assessment of whether those symptoms result in occupational and social impairment." 713 F.3d 112, 117-18 (Fed. Cir. 2013). In *Mauerhan*, the Court held that the symptoms listed in DC 9411 are "not intended to constitute an exhaustive list, but rather are to serve as examples of the type and degree of symptoms, or their effects, that would justify a particular rating." 16 Vet.App. at 442. The Board is required to "consider all symptoms of a claimant's condition that affect the level of occupational and social impairment," not just those listed in the regulation. *Id.* at 443.

Thus, when determining the appropriate disability evaluation to assign, the veteran's symptoms are the Board's "primary consideration." *Vazquez-Claudio*, 713 F.3d at 118. However, "a veteran may only qualify for a given disability rating under § 4.130 by demonstrating the particular symptoms associated with that percentage, or others of similar severity, frequency, and duration." *Id.* at 117. "The regulation's plain language highlights its symptom-driven nature" and "symptomatology should be the fact-finder's primary focus when deciding entitlement to a given disability rating." *Id.* at 116-17.

The Board's determination of the appropriate degree of disability is a finding of fact subject to the "clearly erroneous" standard of review set forth in 38 U.S.C. § 7261(a)(4). *See Smallwood v. Brown*, 10 Vet.App. 93, 97 (1997); *Johnston v. Brown*, 10 Vet.App. 80, 84 (1997). "A factual finding 'is "clearly erroneous" when although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed.'" *Hersey v. Derwinski*, 2 Vet.App. 91, 94 (1992) (quoting *United States v. U.S. Gypsum Co.*, 333 U.S. 364, 395 (1948)).

As with any finding on a material issue of fact or law presented on the record, the Board must support its determination of the appropriate degree of disability with an adequate statement of reasons or bases that enables the claimant to understand the precise basis for that finding and facilitates review in this Court. 38 U.S.C. § 7104(d)(1); *Allday v. Brown*, 7 Vet.App. 517, 527 (1995); *Simon v. Derwinski*, 2 Vet.App. 621, 622 (1992); *Gilbert v. Derwinski*, 1 Vet.App. 49, 57 (1990). To comply with this requirement, the Board must analyze the credibility and probative value of the evidence, account for the evidence that it finds to be persuasive or unpersuasive, and provide the reasons for its rejection of any material evidence favorable to the claimant. *Caluza v. Brown*, 7 Vet.App. 498, 506 (1995), *aff'd per curiam*, 78 F.3d 604 (Fed. Cir. 1996) (table); *Gabrielson v. Brown*, 7 Vet.App. 36, 39-40 (1994); *Gilbert*, 1 Vet.App. at 57.

In the present appeal, because the appellant is proceeding pro se, the Court sympathetically reads his pleadings. *See De Perez v. Derwinski*, 2 Vet.App. 85, 86 (1992). The appellant contends that the Board wrongly discounted the probative value of the evidence from his private treating psychiatrist, Dr. Jabbour, including Dr. Jabbour's assignment of GAF scores ranging from 39 to 45. Appellant's Informal Brief (App. Inf. Br.) at 1, 2; attachment at 1, 2. The appellant also argues that

the Board failed to consider all the evidence in the entirety when assigning a disability rating, that the Board relied on its own medical diagnosis, and that the Board should have assigned a 70% disability rating. *Id.* at 1-3 (citing R. at 289 (appellant's September 2011 NOD)).

The Court concludes that the Board provided inadequate reasons or bases for its decision for several reasons. First, the Board did not adequately explain and support its decision to assign less probative value to Dr. Jabbour's private treatment records than to the VA examination reports. The Board explained that it discounted the GAF scores assigned by Dr. Jabbour because "such low scores were only assigned by the [appellant's] private physician, and upon review of the physician's reports, the low GAF scores appear to be inconsistent with the level of functionality described therein." R. at 12. This statement represents the Board's erroneous substitution of its own medical judgment or opinion for that of the physician. *See Colvin v. Derwinski*, 1 Vet.App. 171, 175 (1991) (Board may only use independent medical evidence and may not substitute its own medical opinion for that of competent medical professionals). Indeed, even the Board noted earlier in its decision that Dr. Jabbour's treatment notes include evidence of suicidal ideation as part of the reason for the physician's assignment of a GAF score of 39. R. at 9; *see* R. at 96-97. Although the Board is permitted to discount the probative value of Dr. Jabbour's treatment reports and GAF scores, it must provide an adequate explanation for its decision that is supported by independent medical evidence of record. *See Washington v. Nicholson*, 19 Vet.App. 362, 367-68 (2005); *Owens v. Brown*, 7 Vet.App. 429, 433 (1995).

In discounting the low GAF scores assigned by Dr. Jabbour, the Board also stated that the scores were

inconsistent with the other evidence of record, demonstrably an ability to hold a job and work and live with others through the appeal period. At no time during the appeals period did the [appellant] exhibit major impairment at work, family relations, judgment [in] thinking or mood, nor was there any indication of serious symptom or serious impairment in social or occupational functioning.

R. at 12-13. However, a review of the record shows that there is plenty of evidence of record that appears to be "consistent" with Dr. Jabbour's assigned GAF scores or with assignment of a higher disability rating of 50% or 70%. This evidence includes symptoms of hallucinations, panic attacks two to three times per week, marital problems, social isolation, significant weight loss, major

insomnia, frequent nightmares, and suicidal ideation. *See* R. at 8-12. The Board's decision therefore does not enable the appellant to understand the precise basis for the Board's reasoning and does not adequately facilitate review by this Court. *See Allday*, 7 Vet.App. at 527.

Second, the Board also did not consider and analyze together all of the evidence of record tending to point to an increased rating of 50% or 70%. In the analysis section of its decision explaining the reasons for its assignment of a 30% rating, the Board erroneously stated that there was no evidence of suicidal ideation. R. at 10, 11. However, in an earlier portion of its decision in which it recounted the evidence of record that it considered, the Board noted that the private treatment records from Dr. Jabbour relay that the appellant "mentioned he contemplated suicide in the past, but 'this suicidal ideation has decreased lately.'" R. at 9. Significantly, Dr. Jabbour stated that the appellant's suicidal ideation had *decreased*, but not that it had *disappeared* completely.

The Board stated that the appellant's symptoms of hallucinations several times per week and panic attacks two to three times per week, do not "alone" support an increased rating. R. at 11. However, instead of considering these symptoms "alone," the Board should have considered these more severe symptoms *together with all of the other symptoms evidenced in the record*, which include suicidal ideation, the appellant's separation from his wife beginning in September 2015, his problems with coworkers and reprimands at work, major insomnia, flashbacks, nightmares, inability to focus or concentrate, anger, irritability, anxiety, depression, psychomotor retardation, hypervigilance, suspiciousness, weight loss, and disinterest in socializing. *See* R. at 8-11. Although the Board noted the existence of these symptoms, it did not, as required, consider the impact that *all of these symptoms together* have on the appellant's disability picture and how, in the aggregate, they affect the level of occupational and social impairment. *See Vazquez-Claudio*, 713 F.3d at 117-18; *Mauerhan*, 16 Vet.App. at 443.

Finally, although the Board noted differing levels of severity or frequency of symptoms—such as hallucinations, panic attacks, and ability to get along with others—throughout the appeals period, the Board did not, as it should have, consider the appropriateness of staged ratings. R. at 9 (noting that the appellant began having marital problems in September 2015, which also caused significant weight loss in a short period of time); R. at 10 (noting that "until recently the [appellant] has maintained a positive relationship with his family"); R. at 11 (noting that "on three occasions" the

appellant "reported panic attacks as frequent as two to three times per month," but that, at other times, frequency was less); R. at 10-11 (noting differing reports from the appellant of frequency of hallucinations during the appeal period); see *Hart v. Mansfield*, 21 Vet.App. 505, 510 (2007) (holding that it is appropriate to assign separate disability ratings for distinct periods, known as "staged" ratings, where "factual findings show distinct time periods where the service-connected disability exhibits symptoms that would warrant different ratings"); *Fenderson v. West*, 12 Vet.App. 119, 126 (1999).

The Court will therefore remand the appellant's claim. See *Tucker v. West*, 11 Vet.App. 369, 374 (1998) (remand is appropriate "where the Board has incorrectly applied the law, failed to provide an adequate statement of reasons or bases for its determinations, or where the record is otherwise inadequate"). On remand, the Board must address the appellant's complete symptomatology as described above and render the requisite two-part analysis required under *Vazquez-Claudio*, 713 F.3d at 118.

In pursuing the matter on remand, the appellant is free to submit additional evidence and argument on the remanded matter, and the Board is required to consider any such relevant evidence and argument. See *Kay v. Principi*, 16 Vet.App. 529, 534 (2002) (stating that, on remand, the Board must consider additional evidence and argument in assessing entitlement to the benefit sought); *Kutscherousky v. West*, 12 Vet.App. 369, 372-73 (1999) (per curiam order). The Court has held that "[a] remand is meant to entail a critical examination of the justification for the decision." *Fletcher v. Derwinski*, 1 Vet.App. 394, 397 (1991). The Board must proceed expeditiously, in accordance with 38 U.S.C. § 7112 (requiring the Secretary to provide for "expeditious treatment" of claims remanded by the Court).

### **III. CONCLUSION**

After consideration of the appellant's and Secretary's briefs, and a review of the record on appeal, the Board's November 16, 2015, decision is VACATED and the matter of entitlement to an initial disability rating greater than 30% for PTSD with alcohol abuse in remission is REMANDED for further proceedings consistent with this decision.

DATED: November 30, 2016

Copies to:

Donald R. Bullock

VA General Counsel (027)